Intake Form

First Name: _____ Last Name: _____

Middle Name: _____ Preferred Name: _____

Sex (circle one): M / F DOB:_____

Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

E-Mail: _____

Employer: _____ Occupation: _____

Marital Status: Married Single Divorced Separated Widowed

Emergency Contact

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Patient Guardian (if applicable) : _____

For the following questions, please circle the best answer.

Text Messaging: We are able to notify you of new lab results, appointments and more via text message. Would you allow us to occasionally text you with important information?

YES NO

Contact Preference: Home phone Cell phone Work phone

Language Spoken: English Spanish Other: _____

Race: American Indian Asian Caucasian/White Black/African American
Filipino Japanese Korean Native Hawaiian/other Pacific Islander

Ethnicity: Not Hispanic or Latino Central American Cuban
Dominican Hispanic or Latino/Spanish Latin
American/Latin Latino Puerto Rican South American
Spaniard

How did you hear about us? Advertising Specialist Physician Word of Mouth
Patient in the practice Hospital Insurance Company
Other: _____

Patient Care Summary: Would you prefer to receive your patient care summaries via online portal or on paper? Online portal Paper

Consent to Call: We have the ability to send automated appointment reminders, messages about test results, and other important information in relation to your health care to your phone. Would you allow us to call you with this system on occasion with information regarding your healthcare? YES NO

Pharmacy Records: We have the ability, through our electronic medical record system, athenahealth, to obtain your medication history from pharmacy records over the last 13 months. Would you allow us to obtain your pharmacy records in this manner?
YES NO

Printed Name: _____

Signature: _____ **Date:** _____

AUTHORIZATION TO RELEASE/DISCLOSE HEALTH INFORMATION

Patient Name: _____ Today's Date: _____

Date of Birth: _____

1. I authorize the use or release/disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the release/disclosure.

_____

Provider(s)

_____

3. This information may be disclosed or released to the following individual or organization:

   St. Gianna Family Medicine
   2135 N. Ridge Rd S-400
   Wichita, Ks 67212
   316-768-6444 Phone
   316-719-2406 Fax

4. For the purpose of: _____
5. The type and amount of information to be used or released/disclosed is as follows:
   ____Entire Record ____Accounting/Billing Information ____Physical Therapy
   ____ASC Records ____Diagnostic/Imaging Reports ____Laboratory Reports
   ____Please specify date(s) or report(s) needed above_____
   ____Other (Please Specify) _____

6. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. ____(Please initial)
7. I understand that treatment is not conditional upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
8. I understand that fees may be charged for preparing and sending copies of records.
9. St. Gianna Family Medicine is not responsible for completeness, legibility or omittance caused by the coping and any medical records from another institution.
10. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the HIPAA Compliance Officer 2135 N. Ridge Rd S-400, Wichita, Ks 67212. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date _____. If I fail to specify expiration date this authorization will expire in one year.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If Signed by Legal Representative, Relationship to Patient Signature of Witness

ST. GIANNA FAMILY MEDICINE
2135 N. Ridge Rd S-400
Wichita, Ks 67212
Phone: 316-768-6444

ASSIGNMENT OF INSURANCE BENEFITS FORM

Assignment of Benefits:

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE OR MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO ST. GIANNA FAMILY MEDICINE FOR ANY SERVICES FURNISHED ME BY THE PROVIDER/CLINIC. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE INSURANCE COMPANY OR TO CMS (CENTERS FOR MEDICARE AND MEDICAID SERVICES) AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. *In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier* as *the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services.*

Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY SAID INSURANCE.

Print Name _____

Signature _____ Date _____

St.Gianna FAMILY MEDICINE

Authorization for use and/or Disclosure of Protected Health Information

Patient Name	Birth Date

1. I hereby authorize St. Gianna Family Medicine to use and/or disclose the protected health information to:

Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #

2. ____ Do not authorize disclosure of Protected Health Information to any family member or acquaintance.

3. Date of Authorization _____.

4. In signing this authorization, I understand and acknowledge the following (initial in the space provided):

   _____ I understand that my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.

   _____ I understand that I may revoke this authorization at any time by notifying St. Gianna Family Medicine in writing of my intent to revoke this authorization, except to the extent that action has been taken in reliance on this authorization. Any notice of termination must be sent to the Privacy Official, 2135 N. Ridge Rd S-400, Wichita, Ks 67212.

   _____ I understand that once the disclosures authorized herein have been made, the information disclosed may be subject to re-disclosure by any recipient and no longer protected by federal privacy laws.

   _____ I authorize and request St. Gianna Family Medicine, its employees, subsidiaries, affiliates, representatives, agents and assigns (collectively, "St. Gianna's") to release copies of my medical and billing information.

5. Email Address: _____

I, the undersigned, do hereby swear that I am the above-mentioned patient or a legal representative of the above-mentioned patient. I have read and understand the above information.

_____ _____

Date Signature of Patient/Legal Representative

_____ _____

Printed Name of Patient/Legal Representative Relationship

HEALTH HISTORY

Name: _____ **Date of Birth:** _____

Reason for visit today: _____

Specialists involved in care:

_____

_____

Immunization History

- ☐ Chickenpox Date: _____
- ☐ Flu Shot Date: _____
- ☐ Gardasil/HPV Date: _____
- ☐ Hepatitis A Date: _____
- ☐ Hepatitis B Date: _____
- ☐ Meningococcus Date: _____
- ☐ MMR (Measles, Mumps, Rubella) Date: _____
- ☐ Pneumonia Date: _____
- ☐ Tdap (tetanus and pertussis) Date: _____
- ☐ Tetanus Date: _____
- ☐ Zostavax (Shingles) Date: _____

Past Surgical History

	Surgery	Reason	Year
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Other: _____

_____

Social History

Caffeine

☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Alcohol

Do you drink alcohol? Yes No

If so, how many drinks per week? _____

Tobacco

Do you use tobacco? Yes No

If yes, what and how much per day? _____ For how many years? _____

If not currently, did you ever use tobacco? Yes No

If yes, what and how much per day? _____ For how many years? _____

Drugs

Do you currently use recreational or street drugs? Yes No If yes, what? _____

Have you formerly used recreational or street drugs? Yes No If yes, what?_____

Past Medical History

Please check all that apply.

- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ Abuse/Domestic Violence
- ☐ Allergies/Hay fever
- ☐ Anemia
- ☐ Anesthesia Complications
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism Spectrum Disorder (ASD)
- ☐ Bedwetting
- ☐ Birth Defects or Inherited Disease
- ☐ Bladder or Kidney Problems
- ☐ Blood diseases
- ☐ Blood transfusion
- ☐ Breast cancer
- ☐ Breast problem
- ☐ COPD
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Chronic Ear Infections
- ☐ Congestive heart failure
- ☐ Constipation
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Developmental or behavioral disorders
- ☐ Diabetes
- ☐ Difficulty swallowing
- ☐ Diverticulitis
- ☐ Ear or hearing problems
- ☐ Eating disorder
- ☐ Eczema
- ☐ Endometriosis
- ☐ Fibromyalgia
- ☐ GI problems
- ☐ Gout
- ☐ Headaches
- ☐ Heart disease
- ☐ Heart problems
- ☐ Hepatitis
- ☐ High cholesterol
- ☐ Hospitalizations
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Infertility
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Lung disease
- ☐ MRSA exposure
- ☐ Meniere's disease
- ☐ Mental disorder
- ☐ Mental illness
- ☐ Muscle, joint or bone problems
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Ovarian cancer
- ☐ Polyps
- ☐ Pre-eclampsia
- ☐ Pulmonary embolism
- ☐ Reflux/GERD
- ☐ Seizures/epilepsy
- ☐ Skin problems
- ☐ Stroke
- ☐ Thrombophilia
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Varicosities
- ☐ Vision or eye problems

Other/Comments:_____

_____

Family History

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	_____	Arthritis Depression Cancer: type_____ Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke Thyroid Disorder Other:_____
Grandfather (maternal)	Y/N	_____	Arthritis Depression Cancer: type_____ Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke Thyroid Disorder Other:_____
Grandmother (paternal)	Y/N	_____	Arthritis Depression Cancer: type_____ Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke Thyroid Disorder Other:_____
Grandfather (paternal)	Y/N	_____	Arthritis Depression Cancer: type_____ Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke Thyroid Disorder Other:_____
Father	Y/N	_____	Arthritis Depression Cancer: type_____ Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke Thyroid Disorder Other:_____
Mother	Y/N	_____	Arthritis Depression Cancer: type_____ Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke Thyroid Disorder Other:_____
Brother/Sister	Y/N	_____	Arthritis Depression Cancer: type_____ Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke Thyroid Disorder Other:_____
Brother/Sister	Y/N	_____	Arthritis Depression Cancer: type_____ Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke Thyroid Disorder Other:_____
Other:_____	Y/N	_____	Arthritis Depression Cancer: type_____ Diabetes Genetic disease Heart disease Hypertension Osteoporosis Stroke Thyroid Disorder Other:_____